HOSPITAL FOR SPECIAL CARE

Adaptive Sports Program

Date: ___________________

Participant Registration Form

Program(s): *(Check all that apply)*

- ☐ Chargers Indoor Wheelchair Soccer Team
- ☐ Cruisers Track & Field and Racing Team
- ☐ Hospital for Special Care Ivan Lendl Adaptive Sports Camp
- ☐ Spokebenders Wheelchair Basketball Team
- ☐ Junior Wheelchair Basketball with Ryan Martin Foundation
- ☐ Inclusive Recreation Events
- ☐ Wave Swim Team

Role(s): *(Check all that apply)*

- ☐ Athlete
- ☐ Coach
- ☐ Volunteer
- ☐ Student Observer
- ☐ Professional
- ☐ Other: _________________

PARTICIPANT INFORMATION

____

Name of participant – last, first, middle

Date of birth: ___/___/___ Age: _______ Height: ________ Weight: ________ Gender: ☐ M ☐ F

____

Home address Number and street City/State/Zip

(______) ______________________ (______) ______________________ ______________________________

Home phone Cell phone Email address

PARENT INFORMATION *(required for participants under 18)*

____(______)__________________(______)__________________

Mother/legal guardian name Cell phone Other

____(______)__________________(______)__________________

Father/legal guardian name Cell phone Other

EMERGENCY CONTACT *(other than parent/guardian)*

____(______)____

Name Phone Relationship to participant

Primary care physician name ____________________________________ Phone (______)____________________

Insurance company name ____

Policy number ______________________________ Policy holder's name _________________________________

HEALTH HISTORY

Primary diagnosis ______________________________ Date of onset ______________

Secondary diagnosis ______________________________ Date of onset ______________

Please check and provide an explanation for any present or past conditions that apply below:

☐ Allergies	☐ Communication	☐ Health	☐ Seizures	☐ Vision
☐ Behavioral	☐ Digestion	☐ Hearing	☐ Sensation	☐ Other *(please list below)*
☐ Bone/joint	☐ Elimination	☐ Heart	☐ Special diet	
☐ Breathing	☐ Emotional/ mental	☐ Muscular	☐ Thinking/ cognition	
☐ Circulation		☐ Pain		

Explanation

____

____

Date of last tetanus shot/booster ______________

Significant Medical Procedures *(Describe procedure and date)*

____

____

Medications *(Include name, dose, frequency for all prescriptions, emergency and over-the counter medications)*

____

____

Adverse Reactions *(Please list any adverse reactions to medications or environmental stimuli that could affect individual's participation)*

____

____

DESCRIBE YOUR ABILITIES/DIFFICULTIES IN THE FOLLOWING AREAS (*include assistance required or equipment needed)*

Physical Function *(i.e. Mobility skills such as transfers, walking, wheelchair use, driving/bus riding)*

____

____

Activity Restrictions

____

____

Psycho/Social Function *(i.e. Work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.)*

____

____

Toileting

Urinary: ☐ Continent ☐ Incontinent Bowel: ☐ Continent ☐ Incontinent

Assistance required by participant/devices used

____

Barrier(s) to participation *(Check all that apply)*

- ☐ Adaptive Equipment
- ☐ Aide / "Buddy"
- ☐ Financial
- ☐ Overnight Lodging
- ☐ Transportation

GENERAL INFORMATION

How did you hear of Hospital for Special Care Adaptive Sports /Mentorship Programs? *(Check all that apply)*

☐ Web site ☐ Newspaper ☐ Friend ☐ Brochure ☐ Therapy clinic ☐ School ☐ Physician office

☐ Other ____

Have you participated in Hospital for Special Care programs before? ☐ Yes ☐ No

Do you participate in adaptive sports or mentorship programs outside of Hospital for Special Care programs?

☐ Yes ☐ No If yes, what programs ______________________________

What are your strengths? ____

Is there a special goal this year you would like to achieve while participating? ______________________

____

Do you have any concerns about participating? ______________________________

____

DEMOGRAPHIC INFORMATION *(requested on many grant applications that help fund the programs)*

Which category best describes participant's race or ethnicity?

☐ African American (not of Hispanic origin) ☐ Asian American or Pacific Islander

☐ Caucasian/White (not of Hispanic origin) ☐ Hispanic ☐ Multiracial ☐ Other ________________

Is participant a veteran? ☐ Yes ☐ No

What category best describes participant's annual household income? *(Optional)*

☐ Less than $24,999 ☐ $25,000 to $49,999 ☐ $50,000 to 99,999 ☐ $100,000 or more

Please return completed registration form to:

Janet Connolly, MS, CTRS, Sports & Community Program Manager
Hospital for Special Care Adaptive Sports
2150 Corbin Avenue
New Britain, Connecticut 06053

For questions please contact Janet Connolly:

Email: JConnolly@hfsc.org
Fax: 860.612.6368
Phone: 860.832.6220

FOR OFFICE USE ONLY

Date rec'vd: ______________________

Additional Forms	Date Sent	Date Rec'vd	Update
Aquatic Rehab Center Registration	______	______	______
HSC Confidentiality Agreement	______	______	______
HSC CRUISER Liability Waiver/Registration	______	______	______
HSC Liability Waiver	______	______	______
HSC Photo Release	______	______	______
HSC Ivan Lendl Camp Medical Form	______	______	______
HSC Ivan Lendl Camp Waiver/Photo Release	______	______	______
HSC Ivan Lendl Camp Medical Authorization	______	______	______
HSC Ivan Lendl Camp Prescription Authorization	______	______	______

Revised 2/2019

Please complete all fields.

Center of Special Care, Inc.
New Britain, CT 06053

AUTHORIZATION TO USE AND DISCLOSE PHOTOGRAPHS/RECORDINGS AND RELATED PERSONAL INFORMATION OF:

{*CIRCLE ONE* : EMPLOYEE or VOLUNTEER or VISITOR or PROGRAM PARTICIPANT}

Name: ______________________________ **Phone:** ______________________________

Address: ____

I give full permission to Center of Special Care, Inc. ("CSC") to take and use photographs, audiovisual recordings of me and/or interview me for purposes of fundraising, publicity, marketing, advertising, media relations and publication of research/public health information, corporate reports, and education materials.

I understand that such photographs, audiovisual recordings, and information obtained during interviews may be used and disclosed in any format for internal and external publication, including radio, television, video, internet, social media and other forms of communication to the public. This includes my permission to use and disclose my personal information that is shared with CSC staff, journalists and representatives of the media during interviews to which I hereby agree to participate, and other facts that can be inferred from the interview, photograph or audiovisual recording.

My name may be used and disclosed as indicated below:

____ **Full Name** ____ **First Name only** ____ **Initials only** ____ **No Name or Initials**

I understand that neither I nor CSC will receive direct or indirect payment for the communication related to photos, recordings, interview or other information obtained under this Authorization. I expressly waive the right to any compensation whatsoever or right to control copying, reproduction, or distribution of any recordings, photographs, or information otherwise obtained in accordance with this Authorization.

I certify that I am over eighteen (18) years of age and have the legal right and authority to sign this form. I understand the meaning of this form, and I hereby release CSC and its respective agents, servants, employees, physicians, officers, directors, and consultants from any claim or liability whatsoever in connection with the taking, use or disclosure/publication of photographs, audiovisual recordings, and information obtained during interviews (including my personal information).

______________________ ______________________ ______________________
Signature Printed Name Date

Relationship to subject: ______________________________________
(if subject is a minor under 18 years or otherwise incapable of signing)

Witness: (If subject is physically unable to sign):

______________________ ______________________ ______________________
Signature Printed Name Date

Form rev. 5-2010; 3-2013; 3/6/2014; 7/9/2015

"CSC" includes all affiliates and operating entities under CSC, including but not limited to Hospital for Special Care, Hospital for Special Care Foundation, Inc., HSC Community Services, Inc. d/b/a Special Care Dental Services and Manes & Motions Therapeutic Riding Center, Inc., including their respective employees and agents.

Hospital *for Special* Care
and Affiliates

Release of Liability

I UNDERSTAND and agree that I will be using equipment, facilities and/or fields at the Research & Education Center (the "Center").

I UNDERSTAND and agree that using the equipment, facilities and fields at the Center involves certain inherent risks, dangers and hazards which can result in serious personal injury and that personal injuries and damage to property are a common and ordinary occurrence in the use of such equipment, facilities or fields. I hereby agree to freely and expressly assume any and all risks of injury to myself or damage to my property while using any equipment, facilities or fields at the Center.

I UNDERSTAND that there is absolutely NO GUARANTEE OF MY SAFETY.

I UNDERSTAND that I am responsible for any damage to the equipment, facilities or fields while it is in my possession. This includes, but is not limited to, theft or loss.

I UNDERSTAND there are NO WARRANTIES, expressed or implied, and that I use said equipment, facilities and/or fields AS IS.

I, for myself and on behalf of my heirs, assigns, personal representatives and next of kin, hereby agree to indemnify and hold harmless, and to release and forever discharge the Hospital for Special Care, HSC Community Services, Inc. and their parent entity, and the respective directors, officers, employees, and affiliates of each such entity, and other participants in any activities at the Center, sponsoring agencies of such activities, and the owners/lessors of the premises ("Releasees"), with respect to all and any injury, disability, death, or loss or damage to person or property, whether arising from the negligence of the Releasees or otherwise, to the fullest extent permitted by law.

I HAVE READ THIS RELEASE OF LIABILITY AND ASSUMPTION OF RISK, FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I WILL BE GIVING UP RIGHTS BY SIGNING THIS AGREEMENT, AND SIGN IT FREELY AND VOLUNTARILY.

______________________________ ____________________

Participant's Name Date:

____

Signature

If Participant is under the age of 18, this form must be signed by the Participant's parent or legal guardian:

____

Parent/Legal Guardian of Minor Participant